Building capacity in the Zambian mental health workforce through engaging college educators; evaluation of a Development Partnership in Higher Education (DelPHe) project.

W.J.Penson; K.Karban; S. Patrick; B. Walker, B.;R.N'Gandu; A.Bowa; E.Mbewe

Abstract

Between 2008-2011 academic teaching staff from a Leeds Beckett University (UK) and Chainama Hills College of Health Sciences (Zambia) worked together on a Development Partnership in Higher Education (DelPHe) project funded by the Department for International Development (DFID) via the British Council. The partnership focused on 'up-scaling' the provision of mental health education which was intended to build capacity through the delivery of a range of workshops for health educators at Chainama College, Lusaka. The project was evaluated on completion using small focus group discussions (FGD's), so educators could feedback on their experience of the workshops and discuss the impact of learning into their teaching practice. This chapter discusses the challenges of scaling up the mental health workforce in Zambia; the rationale for the content and delivery style of workshops with the health educators and finally presents and critically discusses the evaluation findings.

Introduction

This chapter discusses the evaluation of a three year (2008-2011) DelPHe project partnership between Chainama College of Health Sciences in Lusaka, Zambia and the Faculty of Health at Leeds Beckett University[1] in the United Kingdom. DelPHe projects were funded by the Department for International Development (DFID) via the British Council (UK) as part of an ongoing commitment to international development. The evaluation reports on findings from focus groups held with educators at Chainama College following the delivery of educator

[1] Leeds Beckett University was called Leeds Metropolitan University until 2014.

workshops aimed at up-scaling educational provision in order to build capacity in the Zambian mental health workforce. In this context *capacity* refers to the upskilling of mental health practitioners to the most current thinking and practices that reflect best practice and evidence (building capacity was not referring to workforce expansion).

The Context of the DelPHe Project

At the point that the project was running the most up-to-date Zambian census for 2000 records a population of 9,885,591 of which 2.7% is thought to be disabled. 8.1% of the disabled population is recorded as having a 'mental illness' and 5.4% as being 'ex-mental patients'. Together these categories make up 13.5% of the total disabled population (CSO 2000). However, given the stigma and exclusion of people with mental health problems it is thought both in Zambia and globally that this is a conservative figure. While there is no single accepted definition of disability internationally there are commonalities and mental health problems have been increasingly recognized in disability terms. Disability tends to refer to some kind of impairment (physical, sensory, psychological) that either in and of itself, or due to physical/environmental and attitudinal barriers, results in problems or limitations being experienced by the disabled person. Often problems and limitations are judged against normative measures such as the ability to work and also depend upon medical qualification of the impairment both of which remain challenged by disability activists worldwide (Penson, 2015)

Mental health and psychiatry training in Zambia is limited to two institutions, both in Lusaka. The University of Zambia trains Social Workers and provides Medical Psychiatry training along with Chainama Hills Hospital where trainees are attached for six weeks practicum. Chainama College of Health Sciences trains a range of paramedical staff including Registered Mental Health Nurses and Clinical Officers in Psychiatry for three years at diploma level.

Despite active programs at both institutions the mental health workforce struggles to meet the service demands for people experiencing mental health problems largely due to three major factors. Firstly, the mental health workforce is depleted by the problem of 'brain drain' (Mayeya et al, 2004), a term referring to the exit of trained clinicians either to other countries with better prospects, or through retirement or death. Secondly, problems arising out of stigma make the entry into mental health professions a variably respected choice. Mayeya et al (2004) noted that there were just 260 workers in Zambian psychiatric institutions which represented a decline in recruitment, and resulted in an absence of trained staff in a number of service areas. At present there is a small, dedicated mental health workforce at Chainama Hills Hospital (a 200 bed facility) with further psychiatric in-patient provision in general district hospitals, but community and rural health centers are not able to provide such a dedicated provision. Thirdly, Zambia along with other low income countries rations resources by extending mental health care through primary care (Saxena, 2008). The result, in Zambia referred to as the 'brain in the drain', leads to the misplacement of mental health personnel to other jobs. Trained mental health nurses for example are posted by the Ministry of Health (MoH) after graduation to their first jobs; which may be community based rural postings where they are expected to deal with the whole range of health problems experienced by that community, not only mental health problems.

In broad terms this project aimed to up-skill both educators and practitioners in contemporary mental health care and relevant pedagogical practice through educational exchange. As is seen in the next section, such an exchange is not without tensions. A previous paper (Karban et al, 2013) addressed some of the wider contextual challenges involved in 'scaling up' mental health services and the importance of building workforce capacity for mental health practitioners.

The postcolonial context of twenty first century mental health and education.

International collaboration in Higher Education involves a complex partnership that brings benefits and challenges to those institutions involved. The challenges that can hinder the process and delivery of collaboration can include differences and inequalities in the socio-economic political context and locally inequalities include administrative and technical resources and difficulties in accessing opportunities in both pedagogy and subject areas. Working between continents, nations and regions brings a variety of socio-economic, political and cultural differences that have to be negotiated. The British Council, formed in 1934, during a period of international instability, continues to provide opportunities to promote the study of the English language, education in UK culture, and foster UK contributions to arts and sciences in over 100 countries (Borjian, 2011). It is the case that the commonwealth has a direct lineage in Britain's colonial past, and can be seen as perpetuating a 'linguistic imperialism' (Phillipson, 2003). This is a backdrop that continues to overshadow aspects of international mental health collaboration. The wealth and lobbying power of transnational pharmaceutical business continues to have enormous influence (Goldacre, 2012) and promotes the bio-psychiatric model (one that favors biologically based explanations and an investment in ideas of mental illness and psychopathology). Critical writing in the field notes that what might be thought of as distress and trauma are turned into psychopathologies (mental illnesses and diseases) when the dominant bio-medical model is applied. This has led to claims of psychiatric neo-colonisation (that is, a form of colonisation not predicated on the methods of former geo-political and military domination, but rather distally through cultural and economic domination (Mills, 2014). There is a resultant subordination of other cultural and epistemological frames within which to view distress. Psychiatry as a field of medicine has also been charged by scholars as acting as "an agent of globalization" (Kirmayer, 2006, p. 136) enabling governments to distract from difficult conversations about the social circumstances their people endure; instead advancing notions of pathology and individual suffering to replace community responsibility and replace them with individual suffering (Kitanaka, 2012). Furthermore, this subordination (and resistance) is thought to correspond to the possibility that conceptions of mind and wellness follow culturally loaded, Western

prescribed norms (Cox & Webb, 2015; Penson, 2014). Even without the postcolonial context, there is significant and sustained criticism of bio-psychiatry on the basis of an argued lack of scientificity (for example: Bentall, 2003; British Psychological Society, 2013; Moncrieff, 2011). What this meant for our project was the navigation of the dominant psychiatric framework aimed at relieving mental illness 'burden' as part of an internationally accepted drive, while some critical thinkers in the West are losing, or questioning, their confidence in the methods and approaches being exported (White, 2013). The project therefore took a psychosocial perspective that understands medications as just one of a number of strategies to relieve mental health problems and distress, and there was a preference for psychologically informed understandings of mental ill-health that situates the person within their family and social context. Thus mental health problems and distress are understood to be about the interaction between such factors as poverty, trauma, adversity, development, and personal meaning.

The 'DelPHe: Mental Health Project': Rationale

Historically there was a pre-existing relationship between Leeds Beckett and Chainama Hills: a DelPHe project work in Solid Waste Management (2007) and an earlier partnership between the two institutions and the Commonwealth Scholarships Scheme that has taken a number of Chainama College students through the Leeds Beckett University MSc in Public Health.

The project ran between 2008 and 2011 and had the overall purpose of supporting the further development of education and training for the mental health workforce in Zambia. The DelPHe: Mental Health Project principally aimed to build vital capacity at Chainama College of Health Sciences by providing the opportunity for the exchange of skills and knowledge at the level of developing practice, through the provision of workshops in relevant education and mental health practice approaches. The project activity was in line with Zambian mental health policy and strategic plan for 2007 – 2011 (MoH, 2006). However, whilst mental health

was not prioritised in the 2011 *Ministry of Health Action Plan* (MoH, 2011) something which is at variance with the mental health policy of 2004 (MoH, 2004) the *Fifth National Development Plan 2007-2010* (MoH, 2006) does note the need to develop educational capacity in higher learning, including University level research, which is lacking in relation to mental health practice in Zambia (Mayeya et al, 2004).

In attempting to make a significant contribution to the implementation of the Zambian *Mental Health Policy* (MoH, 2004) and *The Strategic Plan for Mental Health* (National Mental Health Services Unit/Directorate of Public Health Research, 2007) through educating the workforce to be fit for practice, the project overall had the following objectives:

1. To update academic and professional staff on current developments in community mental health services and practice;
2. To increase capacity for community mental health developments including the training of mental health workers;
3. To enhance research capacity to support the development of community mental health services.

While this chapter focuses on the workshops aimed at Chainama College of Health Sciences educators, it should be noted that in meeting the broader aims of the project, workshops were also delivered to practitioners/clinicians; volunteer home based workers; carers; members of National Government Organisations (NGOs) and service users. All the workshops aimed to offer an insight into current values, evidence and best practices as understood at the point of delivery in the UK, and given the tensions outlined above, facilitators were clear that the project was about an information and skill exchange, rather than suggesting such content would immediately transfer in appropriateness or practice to the Zambian context.

In addition to workshops delivered in Lusaka and Livingstone, Chainama College lecturers visited Leeds Beckett University, Leeds mental health services, and the University of

Bradford and taught Leeds Beckett University students and staff, and presented at a University of Bradford conference.

The 'DelPHe: Mental Health Project': Delivery & Content

The DelPHe: Mental Health Project aimed to build capacity through the delivery of highly participatory workshops (see Table 1), consultations and networking meetings. All training and development was designed to take account of the evidence base for mental health interventions with individuals and families, as well as an understanding of wider policy and public health issues and the inter-relationship with community development approaches. It was necessary to be sensitive to the different contexts within which evidence-based practice is generated in the developed world and the practicalities and appropriateness of this to Zambia. As such it was important to consider how to generate positive attitudes to mental health to combat stigma, the need for mental health promotion and illness prevention programmes, as well as community based and in-patient services to offer support and treatment to those experiencing mental ill health.

TABLE 1 SHOULD APPEAR ABOUT HERE

Table 1: Schedule of project workshops

It was recognized at the start of the project that the curriculum content for Mental Health Nurses and Clinical Officer: Psychiatry at Chainama College of Health Sciences was extensive, leaving educators with the demanding task of conveying an *over-stuffed curriculum* to the students. As a result of this the prominent teaching style was teacher-centred and content-focused and left little, if any, opportunity for students to develop skills for mental health practice. This was reflective of a practice reality which was that on qualifying and receiving posting by the Ministry of Health, whatever their specialty, clinicians were expected to deal with all-comers; whether that was with a concern of mental health, HIV, malaria or

many other health issues. As such, a packed curriculum was an attempt at sensitizing students to the myriad health issues they would be facing. Therefore the educator workshops were designed to focus on the crucial distinction between content-focused teaching; emphasising transmission of information passively from expert teacher to novice student, and learner-centred teaching which focuses on facilitative, active and participatory learning; necessary for development and application of knowledge (Postaref et al, 2008) and capacity building. The latter also values and aims for a conceptual change within the student which is associated with 'deep learning'; where the intention is to understand meaning, themes, principles and application (Biggs, 2003) generally believed to be preferable to the 'surface learning' associated with content-focused teaching (Quinn, 2000).

Good mental health practice is understood to be related to and dependent upon 'deep learning' by the students. However, 'deep learning' cannot be achieved unless there is consistency in the design and teaching of a curriculum, known as curriculum or constructive 'alignment'. With alignment, the outcome of the educational experience drives the design of the learning environment and teaching strategies employed. This was a concept central to the educator workshops which focused on developing educator skills in designing and delivering curriculum content in an alternative way which should result in consistent learning, internalisation and the conceptual change within students also referred to as 'transformational learning' (Platzer, Blake & Ashford, 2000).

Learning outcomes for practitioner training are by their very definition inclusive of 'practice' elements. In order to maintain constructive alignment assessment of learning is related to behavioural ('doing') learning outcomes. However, the Chainama educators' lifelong orientation to teaching, deeply rooted in the traditional system of teacher centered teaching was divergent to this. It is known that an educator's own exposure to teaching methods will influence their practice (Norton et al, 2005) and that teacher education based on experiential and reflective learning can enable the transformation of teachers in practice, and the critical

reflective skills they develop encourages ideological critique and the ability to imagine a different future and role and to consider themselves as potential agents for change (Carrington & Selva, 2010). Therefore, in order to allow the shift in orientation, the Zambian educators, through the workshops, were exposed to reflective and experiential learning; they 'learned by doing' which gave them the opportunity to experience, gain knowledge about and apply these concepts to their own teaching practice.

Evaluation: Methodology

Evaluating educational interventions is recognised as complex and multi-layered in terms of outcomes and the extent to which learning is transferred and applied to practice. Each of the educators workshops described above was evaluated using standard evaluation forms at the completion of each event. In addition, two focus group discussions (FGDs) involving workshop participants were held some months later. Table 2 below shows the tabulated rating scale for the workshop run in April 2010 for college educators which shows a high level of acceptability of the workshop.

Table 2 to go here.

The evaluation approach draws on a multi-level model of educational evaluation (Kirkpatrick, 1967) that acknowledges the significance of applying learning into practice, whilst also identifying other levels of evaluation. These include providing immediate feedback for trainers on the quality of the delivery and relevance of the content, the integration of new knowledge and the development of new skills. The approach also highlights a clear differentiation between 'output' and 'outcome' in any educational intervention. In this case a distinction is made between ensuring that educators are better equipped to undertake their work, and the fact that this is not an end in itself. The primary objective of the DelPHe Mental Health Project was to improve the quality of the learning experience of the students concerned

and ultimately the intention was an improvement in the quality of the health care delivered by the students for better patient outcomes. Whilst evaluation of this ultimate objective is beyond the scope of this chapter, it is a significant factor that needs to remain central to the overall purpose of the training and the project as a whole. It is relevant to acknowledge that this evaluation design lacks the potential triangulation that might be offered by either obtaining direct feedback from students regarding participants' approach to teaching, learning and assessment and their implementation of new practice, or through third party observation.

Evaluation: Findings

As well as the individual workshop findings through the evaluation form participants where invited to make further comments. By way of illustration the comments for the workshop shown in Table 2 included remarks on the value of workshop content and delivery style. Little came up from participants about what in the workshops was not useful but more comments were made about future considerations including a desire for further training, opportunities for consolidations of skills and theory and the wish for further exchange visits. Participants were also asked to identify one idea to take forward and this aligned closely to the workshop content including being more learner-centered, the use of curriculum alignment to match teaching to learning, and introducing problem based and experiential learning approaches. Some of the themes here were then reflected in the focus group participant responses.

In the final phase evaluation of the project the FGDs invited the participants to reflect on their experience of the workshops and to consider the ways in which they had been able to apply their learning to their practice. Both focus groups were audio–taped and written transcripts were made. Two members of the team independently read the transcripts and organised the data into themes. The themes were then cross-checked. The findings fell under four broad themes, discussed below.

Whilst there may be challenges in evaluating the final effects of a training programme in a systematic way, participants' reports on their own experiences in making changes as a consequence of attending training, begin to address the important question regarding the effectiveness of any training programme, a view echoed by others that: ""value" in learning and training is defined by those who receive the learning or training, not by those who deliver or facilitate it." (Mackinnon Partnership, 2007, p.10)

1. Design of the curriculum

The design was important to focus group participants in relation to who should be involved in the development of the curriculum and what should be included. In the following sections the italicized quotations are from focus group participants.

Balancing the Curriculum: Who to involve?

In the focus groups, educators discussed how course content was currently shaped and then reviewed. They identified a large number of external bodies to take into consideration with curriculum review: '*shareholders...the health professional body, also you get the GNC [General Nursing Council] on board, the ministry of health and others like the University of Zambia School of Medicine and Ministry of Health*'. Students were also mentioned as: '*being able to identify gaps*' and able to have '*input*'. One educator acknowledged that curricula should be reviewed every five years: '*but [they]…have not been reviewed because of constraints*' even though it is understood that there were gaps which needed updating. Participants also identified that supervisors in practice: '*have a lot to say*' and '*Last time we did a curriculum review we went out to those involved in the clinical teaching and also met managers in the area. We also met community members*'. Patients were also mentioned but with prompting.

Curriculum Design

Educators discussed how the job description of the professionals influenced and determined the existing curriculum design. One comment suggested that there still needed to be some clarity about this: '*I also think that it is important to know what kind of cadre we want. Not just overloading them for the sake of it.*' A suggestion was that there should be a link to: '*certain competencies*' for '*mental health in practice*'. One focus group mentioned the imbalance of the mental health curriculum in relation to 'general health' curriculum. One educator commented that the reality in practice is that: '*Mental health is not independent of general health…It can only be seen well when it is integrated*'. They made the point that the patient in the community doesn't go to mental health services: '*they go to the general clinician.'* The impact this has had on the curriculum one educator suggested was that: *'the curriculum was overloaded*' for students. For mental health students they commented: '*they are spending too much time learning general medicine, rather than their specialism*.' This was considered an issue of balance as the course for these students was the same length.

2. Student-Centred Learning

A second theme was that of student-centred learning, a 'new' approach to education. As previously mentioned, educators discussed that students can be involved in the review process and are able to identify gaps in the curriculum. One educator said:

> '*The move away from the lecture, trying to incorporate student centredness, the student is the key and they are the ones doing the job and we are just merely facilitating them in their learning. So I think that is the main change that is happening at Chainama. And I am sure that something will change as a result of what is happening now.*'

Another educator reinforced this shift from lecturer to facilitating learning with students at the centre: '*we are allowing the student to take up their own learning*'. They also spoke of problem-based learning, student presentations and focus group discussions as examples of the 'active' learning approaches now used. One department at the college was mentioned as: '*trying to practice student evaluation where students anonymously make comments about the teacher and the lecture method itself*'.

3. The Impact of The Workshops

This theme arises from comments on the introduction of new learning and teaching methods at Chainama College and the student experience.

Introducing new learning & teaching methods

Educators talked about the changes they had made to their teaching planning and classroom delivery styles that were a direct consequence of attending the workshops. There was discussion about incorporating different 'learning styles'. One educator noted that they were transparent with students about the alignment of 'objectives' in lectures with the final assessment: '*when I am presenting…I have discovered the importance of giving objectives for that particular subject'*. This lecturer continued; *'as a result when it comes to assessment the learning outcomes must match objectives'*.

Both focus groups recognized the value of active participation methods. In one group an educator acknowledged that they were working to replace memory based teaching and learning activities with teaching activities that would promote deeper learning experiences*:*

> '*Another challenge for me has been moving away from definitions. Because in this previous workshop, they really stressed reflective learning, deeper, not only just memorising the concept, in their own words, applying the concept, in their own way'*.

In the other focus group, the educators highlighted that: *'we have learned the need to broaden delivery methods, with students participating actively as well as using other methods such as role-play'*. This was understood by them as an overall improved teaching style, and they had *'learnt how to make this course practical. Sometimes I go out to look for a video to show students on how CPR or other skills can be practised*'.

Reported Students responses to changes in Learning and Teaching styles

Educators reported that they had experienced some resistant responses from their students to changes from 'chalk and talk' or 'preach' approaches to more active and participatory approaches. One educator said: *'... a situation where you give students work to go and read on their own, they thought I was giving them more work.'* Another highlighted they: *'have been labeled various names because ...I don't set definitions, the questions are not as straightforward as they used to be. That's a challenge ... [I'm] now trying to redeem myself as being a good person'*. One group discussed what students have said to them in relation to a change in teaching practice:

> *'Critical thinking (students responses were reported) Why don't you just ask straightforward questions? (focus group laughter) You are making us now, to sit and think, thinking……it takes a lot of time…'*

4. <u>Challenges</u>

Both focus groups were asked about things that would hinder putting new things into practice, which generated discussion around resources linked to learning and teaching materials. One educator mentioned that doing paper based teaching evaluations would be difficult: *'you need a lot of paper…we know we don't have paper'.* Media and information technology resources were also mentioned as being a challenge to access:

> *'In mental health we lack videos, not many that we can actually demonstrate patients behaviour, symptoms and certain disorders, it's basically theory, sometimes you have to improvise if you don't go to internet they are lost…This is where we need to improve, we need to use a lot of illustrative aids that will show clearly things…'*

Finally, student responses to changes in teaching styles from directive to facilitative were mentioned as being problematic, especially if there were significant differences in practice from educator to educator:

> '*…students may not know from word go what is good for them. They see that one (educator) is giving us notes and when exam comes they can simply reproduce same*

notes, but if you are a good lecturer if you give a test to students you don't necessarily…'.

From the focus groups therefore we can understand that the number of interested parties contributing to the design of the nursing and clinical officer curriculums along with the fact that when workers are employed, they are not able to specialise in mental health makes rationalising and focusing curriculum content a challenge, and results in the tendency for the mental health students to be overloaded with information. Zambian educators recognise this and desire a move toward learning approaches which equip the students to deliver mental health interventions aimed at improving patient outcomes. However, they have experienced some resistance from the students who find these active and participatory approaches contra to their previous educational experiences. Additionally, attempts to design and deliver curricula in this 'new' way have been compromised by the establishment infrastructure and resources.

Conclusion

There is a range of challenges towards up-scaling any educational environment, and in the Zambian context there are also some considerable barriers both in further and higher learning. Such challenges range from meeting the educational and development needs of a particular workforce in line with the expectations of a Ministry of Health policy, through the aspirations of educators and practitioners, and on to the material and infrastructural limitations that Chainama College of Health Sciences experiences. In the focus groups, educators did confirm that training within a specialism was often lost when graduates were placed in clinical areas due to the range of tasks health centres oversee. This included psychiatry/mental health trained practitioners spending considerable time treating HIV related illness, malaria, epilepsy and tuberculosis.

Despite this, the project evaluation has indicated that the new educational practices that were shared with Chainama Hills educators were valued for their learner-centeredness, relevance and applicability. Concerns about cultural transfer were less evident than anticipated with a high degree of acceptability being shown for the methods being used in a UK context; for example, a greater use of problem based, experiential and reflective learning. Where acceptability is in question it appears to be in the material ability to deliver some learning within available resources; for instance access to a range of library sources or the suitability of buildings. Feedback from educators about their learners indicated that there was some resistance to what would be more self-directed learning as opposed to the traditional lecture. Additionally it was noted by the project team that service user and family voices are yet to be integrated into the design and delivery of clinical training. At present there is a paucity of literature that deals with the up-scaling and development of higher learning in the sub-Saharan African context. The careful attention to collaboration, exchange and reciprocity, we believe, ameliorated as far as possible, the concern that methods and ideas were unquestioningly favouring of UK practice.

Whilst the project offered workshops in a range of educational approaches to educators at Chainama, it remains beyond the scope of our data to be able to claim development and capacity building to a great extent. However, participant feedback has indicated that the methods and content of the project delivery demonstrated that it had acceptability, relevance and engendered a hope for change and development in the educational environment. These are not insignificant claims as in the future, work could build on the project training in pedagogical practices to support the transfer of a range of teaching and learning practices into routine delivery.

References.

Bentall, R.P. (2003). *Madness Explained: psychosis and human nature*. London: Penguin.

Biggs, J. (2003*). Teaching for quality learning at university*. (2nd ed). Maidenhead: SRHE & Open University Press.

Borjian, M. (2011). The Rise and Fall of a Partnership: The British Council and the Islamic Republic of Iran (2001–09). *Iranian Studies*. *44*(4). 541-562.

British Psychological Society. (2013). *DSM-5: The future of psychiatric diagnosis (2012 – final consultation): British Psychological Society response to the American Psychiatric Association*. Leicester: British Psychological Society.

Carrington, S., & Selva, G. (2010). Critical social theory and transformative learning: evidence in pre-service teachers' service-learning reflection logs. *Higher Education Research & Development. 29*(1). 45-57.

Cox, N., & Webb, L. (2015). Poles apart: does the export of mental health expertise from the Global North to the Global South represent a neutral relocation of knowledge and practice? *Sociology of Health & Illness*. 37(5). 683-697.

Central Statisticals Office. (2000). *Census Data from Zambia*. Central Statistics Office. www.zamstats.gov.org. Accessed 13.25, 28/01/12.

Goldacre, B. (2012). *Bad Pharma*. London: Harper Collins.

Karban, K., Bowa, A., Mbewe, E., Ngandu, R., Patrick, S., Penson, B., & Walker, B. (2013). Scaling Up Mental Health Services in Zambia: Challenges and Opportunities Reported in an Education Project. *International Journal of Mental Health. 42*(2-3). 60-72.

Kirkpatrick, D.L. (1967). Evaluation of training. In R.L. Craig & L.R. Bittel (Eds.), *Training and Development Handbook* (pp. 87-112). New York: McGraw-Hill

Kirmayer, L. (2006). Beyond the 'New Cross-cultural Psychiatry': Cultural Biology, Discursive Psychology and the Ironies of Globalization**.** *Transcultural Psychiatry. 43*(1). 126-144

Kitanaka, J. (2012). *Depression in Japan*. Princeton University Press.

MacKinnon Partnership. (2007). *A Literature Review of the Relationship between Quality Health Care Education and Quality of Care. A report to Skills for Health*. Middlesex. The MacKinnon Partnership.

Mayeya, J., Chazulwa, R., Mayeya, P.N., Mbewe, E., Mgolo, L.M., Kasisi, F. & Bowa, A.C. (2004). Zambia mental health country profile. *International Review of Psychiatry. 16*(1-2). 63-72.

Mills, C. (2014). *Decolonizing Global Mental Health: The psychiatrization of the majority world.* Hove: Routledge.

Ministry of Health. (2004). *Mental Health Policy Final Draft*. Ministry of Health, Zambia.

Ministry of Health (2006). *Ministry of Health, Fifth National Development Plan 2007-2010.* www.moh.gov.zm. Accessed 14:15, 28/01/12.

Ministry of Health (2011). *Ministry of Health Action Plan*. www.moh.gov.zm. Accessed 14.12, 28/01/12.

Moncrieff, J. (2011). The Myth of the Antidepressant. In M. Rapley, J. Moncrieff, & J. Dillon. (2011). *De-Medicalizing Misery: Psychiatry, Psychology and the Human Condition.* Basingstoke: Palgrave.

National Mental Health Services Unit/Directorate of Public Health Research *Strategic Plan for National Mental Health Services 2007-2011*. Ministry of Health: Zambia.

Norton, L., Richardson, J., Hartley, J., Newstead, S. & Mayes, J (2005). Teachers' beliefs and intentions concerning teaching in higher education. *Higher Education. 50*. 537-571.

Penson, W.J. (2014). Psy-science and the colonial relationship in the mental health field. *Mental Health Review Journal*. *19*(3). 176-184

Penson, W.J. (2015) 'Unsettling impairment: mental health and the social model of disability'. Spandler, H.,Anderson, J. & Sapey, B (Eds) *Distress or Disability? Mental Health and the Politics of Disablement.* London:Policy Press.

Phillipson, R. (2003). *Linguistic Imperialism*. Oxford: Oxford University Press.

Platzer, H., Blake, D. & Ashford, D. (2000). An evaluation of process and outcomes from learning through reflective practice groups on a post-registration nursing course. *Journal of Advanced Nursing. 31*(3). 689-695.

Postaref, L., Katajavuori, N., Lindblom-Ylane, S. & Trigwell, K. (2008). Consonance and dissonance in descriptions of teaching university teachers. *Studies in Higher Education. 33*(1). 49-61.

Quinn, F. (2000). *Principles and Practice of Nurse Education*. (4th Ed). Cheltenham: Nelson Thornes.

Saxena, S. (2008). Mental Health: A Global Perspective from the World Health Organization. *Making Mental Health a Global Priority Section II*: World Federation for Mental Health. 3-8.

White, R. (2013). The Globalisation of Mental Illness. *The Psychologist*. *26*. 182-185.